2013-11-07 -- COVERED CALIFORNIA TRIBAL CONSULTATION
PART I

PETER: It's a real privilege to be with you today. I had the chance to meet some of you a year ago. This has been both a very, very fast-passing year—a lot has happened—and we are right now at the edge of, as Mark noted, a really historic event. Those of you that I had a chance to meet last year know that I've got a little bit of familiarity with Native Americans in my family. My uncle was the Assistant Secretary of Health under Bill Clinton and spent a lot of his time focusing on how to make the Indian Health Service work well. I've actually had the privilege of talking to him as an elder to me that I've learned a lot from. Before starting my remarks, though, I'd like to take a moment to honor and recognize one of your elders, which is Jim Crouch.

Jim, as you all know far better than I, has been a champion for many years, and is retiring, giving leadership to Mark, a great leader. I think he's going to do a wonderful job. While you know what he's done for the last 30 years, I know something about what he's done in the last couple years. Jim has played a really crucial role of helping Covered California get off the ground in a way that aggressively and positively engages in partnership with the Native American community. He's been crucial in helping us shape what I think is a model of how we work together. Jim, I'd like you to come up. We actually have a shirt for you that is Covered California for American Indians, because that's what you've helped lead us to do and what we will try to practice. And we know that you will be sort of looking over our shoulder and have our back, but you have been such a leader to help us be a model of how to work together, we wanted to give this as a tribute to you. [applause]

JIM: I'm recommending retirement to all of my aged peers. Everybody is so nice to you. Peter, I'd like to give you a pin that we handed out at the CRIHB annual meeting a few weeks ago. It's "I ♥ ObamaCare." [laughter] [applause]

PETER: Thank you so much. And I do. It's true. We very much look forward to working with Mark, and we've enjoyed our working relationship already with Mark. I think today is a very full day. We have a lot to do. Before jumping into the slides and giving you some background and context, I want to introduce some of the other people that you have the names of. One of our chief deputies, David Maxwell-Jolly, is with us today. He's going to be with you throughout the day. I do note I'm going to need to leave, but I'm going to try to come back for the wrap-up portion. As you can imagine, I have a few balls in the air right now. But we also have, in particular, two people that have just been great, I think—and we need to hear it from you—in working in partnership with you on a day-to-day basis, with is Jessica Abernathy and Natalie Chavez, who are both here with us. Can you stand up, Jessica? You might've seen an email from Jessica. This is Jessica. Do make a point to meet her in person. But also you'll be hearing from

staff, Leah Morris. Again, we are here not just to talk at all to you, but to talk with you, to hear from you. So this is an opportunity for us to learn, to listen, as well as to share where we are.

I would note, before going into the presentation, which sort of frames things, is there's a lot of talk nationally about computer glitches and that we aren't having them in the way that the rest of the country is. That's important, I think, that having the enrollment system work, though not perfectly, and there's actually some little bumps in the road, specifically to some of our Native American enrollment issues. But overall our system is working great. That's not why things are working really well in California. Things are working well in California because for two years we've been working in partnership with tribes. We've been working in partnership with community clinics, with local organizations in rural areas, in cities. I've been doing a lot of public speaking. I've been at town halls. Of the innumerable town halls I've been to, I've been heckled one time. We don't live in Texas. We don't live in Florida. That one time I was heckled was by someone who said, "Don't invade Syria." "Excuse me?" So the point of that is that here in California, we're all about making this thing work, and that's why it's such a privilege to be with you, who are partners with us in making this thing with us for the 70,000 American Indian and Alaska Natives who can benefit specifically by their eligibility for subsidies under the Affordable Care Act with Covered California.

With that, I'm going to go through some context and background. Again, I know that for some of you this will be old hat. Some of you are new. How many of you were at last year's consultation? Can you raise your hands if you were here at last year's? So that's about a third. So two-thirds of you weren't at last year's big consultation. We're going to be going through, pretty quickly, some of the basics in my overview. You'll be hearing much more detail for Leah, and we'll be going through details throughout the day. All of this, though, is framed in engagement of: Are we getting it right? How do we improve? That's our modus operandi.

We have no glitches generally. But every now and then, when we have a glitch, we rock right through it. So let me start with the goals. Again, the main thing that I would note—and again, I'm not a PowerPoint reader. PowerPoints are up here so you can get copies of them and refer back to them later. The two things I would note about our goals is consultation is, first, engagement and partnership. This has got to be about a partnership with you. You know your tribes. You know your communities. You know how to communicate, how to reach out to them, how to build the tools to reach out. We don't. So how do we work with you? That's number one. And number two is the last one, the last bullet, which is the common goal is we want to maximize participation of American Indians in Covered California. This is all about helping people get coverage if they need it and get access to care when they need it. That's our job one. All of our goals are around this. We're sort of a results-oriented organization. That result is all about what we're looking for.

Let me remind you of some of the benefits specific to American Indians and Alaska Natives under the Affordable Care Act. They are very, very big and very substantial. First, the Affordable Care Act provides health insurance that may pay for services that are not otherwise provided, things like medical specialists, tests, emergency room visits, hospital care. Absolutely—and it's very, very important to underscore that American Indians and Alaska Natives can keep using their tribal and urban clinics. We know that the tribal and urban clinics are vital parts not only of the community, but of making sure your tribe members get and stay healthy. This isn't an initiative in any way that's doing anything but reinforcing and supporting that. But also it's very important for folks to understand that the benefits to American Indians are to have zero cost-sharing plans through Covered California. That is a very big deal benefit. You're going to hear more about that later in the day and some of the details of benefit design. But it is a very substantial benefit.

So, writ large—these are issues that are specific across the nation and across California—what are the improvements the Affordable Care Act has done for the nation? First, I'd like to remind us that starting January 1, we are at a new era of healthcare for America. Up until now, when you look at the patchwork of coverage, we as a nation have not said, "Healthcare is a right." It's been a privilege. If you can afford it, or fit into a particular category, you get healthcare. That's changing. As of January 1, 2014, healthcare is now a right, not a privilege, and a number of things make that happen.

First, guaranteed coverage—that means you cannot be turned away based on your health status. The health insurance game of last year was insurance companies avoiding sick people. No more. So health insurance can never turn someone away for pre-existing conditions if it's in open enrollment. We'll talk about that. For people who get coverage and have coverage, no annual limits—huge. Rates are not based on health status. So outside of the tribes, the issues—when you look at how rates are adjusted, it's based on age and income. That's it. And where you live. But not health status. Large employers are required to offer coverage. That actually starts next year, 2015, not 2014. And individuals are required to have coverage. And if they don't, they will have a small penalty.

But the other element that's not on the slide that's very important, the number one name of the Affordable Care Act is "affordable." The other thing the Affordable Care Act does it provide financial support to make healthcare affordable. Based on incomes, sliding scale, financial support to all Americans can actually afford healthcare. So what can they afford? The Affordable Care Act actually lays out what are called "essential benefits." Ten essential health benefits. So whatever health plan you get will cover these ten standard things. They're the things you'd expect, which is not just outpatient care and inpatient care, but mental health services, prescription drugs, rehab. And every plan is covering the same mix of benefits. So it's not that, "Oh, I thought I had insurance." But then when I have to

get care, “Oh, that’s not covered?” All essential benefits are covered under the Affordable Care Act. Now, it’s a national standard but it’s implemented state by state. Our roster of how these are covered is specific to California. But basically, consumers can know, if you get coverage, it’s going to have your back when you need to get care.

Let me tell you a little bit about Covered California. The first thing I'd note is we are a part of the State of California. I report to a five-member board. That board is two members appointed by the governor, two by the legislature, and one is the Health and Humans Services secretary. That’s my boss, that five-member board. We aren’t part of the executive branch, so we don't actually report up to the governor. We’re an independent agency who have one job and only one job, which is to help expand coverage for people throughout the state. That’s our job.

Now, our board, over two years ago, established a vision statement and a mission statement. I think they’re both important to frame how we engage in what we do. The first element was to say that our vision is one of all Californians having access to care. That’s important when we think about the role of tribal clinics. It’s not about coverage; it’s about people getting care. And it’s not about coming through us. It’s about, wherever people are in the state, we need to recognize: How do we reinforce existing delivery systems? How do we be mindful of unintended consequences for that endpoint of care?

Our mission, though, what we do day in and day out, is try to expand health insurance coverage. We do that with an eye on two or three core things. First is affordability, to keep healthcare in front of people, it needs to be affordable. But it’s not just about the dollars. It’s about quality, in particular looking at disparities of care. Members of the American Indian community are hit differently by health conditions than are other parts of the community. Our board says that’s a core element of our mission, to look at how disparities of care play out across the state. It’s also, though, about giving consumers the ability to make choices that are right for them. So that’s our mission. We’re all about expanding coverage to California.

As I noted, we are state based. We’re a state agency. California was actually the first state, after the passage of the Affordable Care Act, to say, “We are going to do this a California way.” There are now 16 states and the District of Columbia that have said, “We are going to run a marketplace and implement the Affordable Care Act for our state.” So Oregon, Washington, Colorado. Now, 34 states have said, “You know, we don't really want to play. We’ll let the federal government administer the marketplaces there.” So when you all hear about the HealthCare.gov website not working, that is because 34 states said, “We aren’t going to make sure to take care of our citizens.” They left it to the federal government, in many ways without telling the federal government early enough they were going to leave it to them, so the federal government was left late in the process to figure out how to serve a huge sector of Americans. It wasn’t it for us. Over two years ago, we said, “We’re going to do it right for Californians,” and

we've been doing it for the last two years. And we've started enrolling people as of October 1. We are, as you'll see, a dotcom, but are very state run, and we offer private health plans.

So, what do we offer? Well, it's health insurance that is affordable. And you're going to hear some of the numbers later. It's premiums based on income, which means lower-income Californians get a huge leg up. Now, in particular, one of the other things California did—and this is not under Schwarzenegger and the democratic legislature that actually founded Covered California and the exchange, but under Jerry Brown and the legislature, is to say, "We, in California, will also expand our Medi-Cal program." So about 1.4 million Californians will get access to expanded Medi-Cal. About 2.6 million Californians will get access to a financial subsidy to help them buy health insurance. That's four million Californians getting financial help to make healthcare affordable.

You're going to hear more later about the benefit designs. But the thing that I would underscore is we spent a lot of time designing the benefits. What are the co-pays? What are the deductibles? The health plans through Covered California can't make it up on their own. They have to offer our standard benefit design. We designed the benefits to be about encouraging consumers to get access to care, not to have, what has historically been the case, sadly, having benefit designs being so confusing and so gobbly-gooky they actually deter people from getting care. So the designs are very specifically oriented to make sure that a consumer will get care at the right time, all the time.

Now, for American Indians, the benefit designs are actually not as significant because of the zero cost sharing. We'll talk more about that. But for non-American Indians that are out in the market—so when you talk to your friends, the issue of having standard benefit designs is a very, very big deal, because every plan has the same deductible. Every plan has the same rules. So consumes that are shopping can do apples-to-apples comparisons.

So what do we offer? There's 11 health plans available throughout the state, but it's different depending on where you are. Now, many of you are in tribes that are in relatively rural areas. In those areas, you probably are not going to have six health plans to choose from, as you would in Los Angeles. You might have two, you might have three, or you might have four. But across the state, there are these 11 health plans. And what you see among these plans is the biggest plans that serve the individual market today, plans like Kaiser Permanente, Anthem Blue Cross Blue Shield and Health Net, but also plan in some of the urban areas that are anchored in serving low-income communities, that have a history of doing that, plans like Molina, LA Care, and ValleyCare. You'll see plans that are anchored in their regions, plans like Sharp in San Diego area and Western Health Advantage in the Sacramento area. We went through a process to select these plans, being what's called an "active purchaser." We did not say, "If you want to be in Covered California, come on down; we'll take everyone." We said, "We're

going to kick the tires hard. We're going to make sure you're going to put in place systems to make sure people get care when they need it." And we ended up selecting these 11 plans, as well as 6 dental plans. The dental coverage, out of the gate, is only for kids. I noted those essential health benefits. There are two elements of essential health benefits that relate to pediatric care, to children. One is dental care and the other is vision care. Those are essential benefits for children. Now, this is not to say that dental coverage is not important for adults. But it's not eligible for the financial subsidies. And Covered California is going to be looking at adding dental in 2014, we hope, but we focused on getting started with our core offering, which is dental coverage for kids.

To underscore a couple of the elements that are special for American Indians and Alaska Natives, reduced or no cost sharing. This no cost sharing is saying instead of having a $45 office visit, it may be zero. And that's a very important, special set of benefits. Consistent care from community providers—now, we've done a lot of work to encourage plans to work with tribal clinics. I know one of the issues we've had, very clear and direct advocacy is not just to encourage but to require. That's not something we'll doing right now. It's something we'll be willing to talk more about. Our general philosophy, with the plans we contract with, is not to require them to do specific contracts with anyone. As you can imagine, this isn't just an issue with tribal clinics. We hear this with federally qualified health centers. A range of providers say, "You must require them to have us in." We've gotten a lot of encouragement and so far have not said "require." As soon as you say "require," what that means for negotiations, etc., makes things a little off kilter. But it's something we're happy to talk about more.

There is, for American Indians and Alaska Natives, special enrollment processes. I noted the issue about pre-existing conditions. For non-American Indians, open-enrollment period is a very consequential thing. So starting October 1 and going through March 31st, that is the period in which you cannot be turned away for a pre-existing conditions. That's the period during which you can get that federal subsidy. Well, for American Indians, the ability to enroll is year round. So it's a different rule on enrollment. And there is also an exemption from the tax penalty. So individuals—I noted the penalty for large businesses will take effect next year. But for individuals who have access to affordable coverage, they will be subject to a penalty starting in 2014. That penalty will be $95 or 1% of your income, whichever is greater. So if you make $30,000, you'll have a penalty of $300. American Indians are exempt from the tax penalty. But I would encourage you that a core part of our partnership with you is the penalty is not the issue. The issue is getting people into affordable coverage, and that's whether or not you're a Native American or someone else. There's talk about the penalty. People want and need health coverage. The real penalty is to actually need care and not be able to get it. And that's what we're focusing a lot of our outreach on.

So let me talk to you a little bit again about going back to the core element of affordability. I noted 2.6 million Californians will be eligible for subsidized care.

About 70,000 of those are members of your tribes. We would like to see every single one of them sign up to get their subsidized care. How does the Affordable Care Act make their care for affordable? Well, first my premium assistance, to lower the cost of what the premium is. And that is on a sliding scale. Lower income gets federal support that goes directly to the health plan people choose. Lower-income people, bigger subsidies. But also—and this is a very important element—it reduces out-of-pocket costs. These are specific benefits to the Native Americans and American Indians. So, if you're a federally recognized Indian and your income—again, there's different income points, but the basic point is 300% of poverty, which is about $34,000—then no cost sharing. So you'll hear more about the benefit designs that have when you pay $40 for a visit, etc. But if you make less than 300% of poverty and are a federally recognized Indian, no cost sharing. There's never any cost sharing for tribal members seen at tribal urban clinics. You guys know that. The other piece, though, for American Indians that are above 300% is they benefit from the sliding scale benefits of support and potentially reductions in their cost sharing.

The other thing we work on is to make sure it's all as transparent as possible. So this goes through the eligibility to help with the premium, to give you some sense that—the main thing that I would highlight—again, you have copies of these slides, and I'm not going to go through them—is I want to underscore that the Affordable Care Act is not a poverty program. First, access to Medi-Cal is expanded under the Affordable Care Act, with now clean and simple rules. There's no asset test. It's just income. That's it. But access to the financial support for subsidies through Covered California goes up. For a family of four, for potential eligibility, for a family that makes $94,000. That's a lot of money. And that's because the Affordable Care Act is about helping all Americans get access to healthcare.

Now, if you have healthcare coverage through your job, you might actually not understand how expensive healthcare is. It is expensive. The Affordable Care Act has not made healthcare cheap in America. What it's done is give millions of Americans a financial leg up that many of us who have employer-based coverage get through our job or get, when we get old enough, on Medicare. So it's just important to note that what the Affordable Care Act does is sliding-scale financial support—which doesn't mean it's free; lower-income people will pay a much smaller share and it can be virtually free or free to them. As you make more money, you're going to pay more.

The premium rates are very simple. There's not asset tests. There's not health screening tests. It's age. It's where you live. It's your household size. And then what you pick. So you can pick one plan that costs a lot because it's got a lot of benefits or another with less benefits. It's your choice. It's not based at all on health status. It's not based at all on gender. This is an issue and other states have actually dramatically different rates based on gender. California has not, but you'll hear people talk about ending the fact that being a woman is no longer a

pre-existing condition. For many states, that's the case. Rates will be much higher for women. It's crazy, to my mind. So it's very simple what the rates are based on.

So we've got what we think are very affordable products with the financial support. We then need to get out there and enroll people. I'm actually going to pause here and talk about something that's not on the slides, which is something that we need you in partnership with. Our success in the end is anchored in three things: Having affordable care, which we have; doing really good outreach, so every single person that is eligible knows about the benefits; and then smooth enrollment. Now, there's not slides on outreach, but this is where you come in. This is where we hope that you, going back to your tribe, will make sure that every single member of your tribe knows about the benefits, whether you communicate through email, through meetings, through Facebook. By the way, how many of you are on Facebook? Raise your hand if you're on Facebook. When you guys get back to your hotel room or get home, like us on Facebook. Over 100,000 Californians have liked us. And send that link to everyone in your tribe. We're out there on social. But the outreach is critical, and this is one of the core things we need from you. The benefits of the Affordable Care Act to American Indians are huge, but only if they know about them.

You help make sure all of your tribes know about them. What do we then do? Smooth enrollment. So let me talk to you briefly about enrollment. First, you'll see on our website at CoveredCA.com—which, I must say one more time, is working just fine—under programs and partnerships, there's a section for California's tribes that has material, background material you can get access to. We designed, right out of the gate, tools specific to your community. Also you'll see on here this "shop and compare." It's easy to find out what your plan benefits are, what they cost, based on your region. And we've done a lot to make it easy. So you'll see also, when you go and click on "start – get covered," information about coverage, a pull-down, one of the key things you can find out more about are American Indian tribes. We have taken a very concerted effort to have concrete information available that is specific, because the benefits are different. The benefits are specific. And the benefits are very, very big. Then you'll see resource materials specific to American Indian tribes.

The website is good. It's not perfect. But I will note—and I don't think there are reporters here, but if there are, this is on background—we actually survey everyone who goes through the enrollment process. 70% say it's easy to enroll. You hear a lot of horror stories about glitches and websites not working. 30% either somewhat difficult or difficult. I don't know how many of you did your taxes on TurboTax or had to fill out an insurance form. I find those difficult right out of the gate. The fact that we have 70% of Californians that have gone through the process saying it's easy is good news. That said, we think a lot of people need help from human beings. So there are five ways that you can help members of your tribe get help. They can go online. But they can call our service center. We

have, right now, 650-700 people trained, and we're actually opening an office in Fresno by the middle of this month, so we'll have like 800 people ready to answer the phone. If someone in your tribe is confused, give them the phone number.

We also, though, have certified agents. This is licensed insurance agents that have been certified to help people out. We also have certified enrollment counselors. You're going to hear more about the opportunities for tribes to have certified enrollment counselors to help people enroll. And finally, we work very closely in partnership with counties. So at every county in the state, the Social Service office has people trained to help people enroll. And it's very important to note that any of these work. There's no wrong door. All of them have been trained to understand the issues with regard to the American Indian community.

Some of the enrollment dates that I've already underscored are: First, open enrollment, which is a very big deal generally, ain't such a big deal for American Indians. But getting coverage is a big deal. So encourage people to sign up because they won't be able to get access to that specialist or those hospitals through a particular plan unless they're insured. So getting signed up sooner is better. But it's not limited to the open enrollment period, number one. Number two, and this is a very specific, different benefit than is there in general, is American Indians and Alaska Natives can change their health plan. Now, this is not the standard rule. I generally think it's a bad idea, because you generally want to have continuity of care. You want to get a relationship with a doctor, with a hospital, etc., but you have the right to change your health plan. Not three times a month, but once a month. But again, I'd encourage folks to think about their relationship with their clinicians in terms of keeping continuity of care. I noted we have a call center. It's open Monday through Saturday. We have [..?..] languages.

Now, I want to sort of do a quick review of what's coming down the track for the balance of today's consultation. My goal was to set up generally what's coming down the track and give you a basic orientation. But you have a very full agenda for the balance of the day. You're going to hear from experts in a number of the areas about issues, specifically plan management, what are the rules in terms of the health plans we're contracting with, what are the rules for access and the benefit designs? You're going to actually, after lunch, see a demonstration of the website to actually show you how it works and how the pull-downs work, etc. and a couple things that I would note in all areas—you're going to be hearing from us, but we do not think we are perfect by a long shot. The reason we think we're pretty good is that we've been listening to you for the last two years, you and others. And so as you go through the day, this is a consultation, so we'll be presenting information to you, but in the spirit of saying, "How do we improve this? How do we do a better job?" Because what we are doing right now is starting what is going to be the healthcare system of the next generation. We are, right now, midway through month two of an enrollment process for coverage that won't start until January 1. We are already spending time back at the office thinking about, "Huh, how are we going to change things for 2015, for 2016?"

Because what we are doing is truly historic. Just as 50 years ago we embarked as a nation on Medicare, we're now embarking on a system that's going to cover all Americans. So we will need to be nimble. We'll need to make adjustments. And the way to do that is to hear from you. These are some of the elements you're going to hear about throughout the day. I am worried about going over time. Mark, do I have any time to take questions? I do. I've got time to take a couple questions, but I'd remind you that looking at the agenda, many of the issues that I covered at a pretty high level is exactly what the rest of the agenda is going to get through. But I would welcome any questions or comments as we get going into the day. If you have an overall observation of how you think we've been doing in the last year, or how we can improve, I'd welcome that. And if you don't mind, reintroduce yourself.

MARK: For this agenda item, we're working with Peter until 10:15, so we have a pretty good time to talk with him. And then immediately at 10:15, we have to have Cynthia, the governor's tribal liaison, come on. She has to go back to a cabinet meeting, so the timing of this session is really key. So yeah, definitely you're welcome to stand at the mic. Introduce yourself, your tribal representation or tribal organization, and share your information.

MICHAEL: Good morning. My name is Michael Garcia. I'm a vice chairman for the Ewiiaapaayp Band of Kumeyaay Indians, and I'm also a board member for the Southern Indian Health Council. I just had a quick concern that I was asked to bring to you guys. I don't know if you're the ones that need to address it. Say, for instance, I'm a 20 to 25-year-old Indian male, no family, occasional work. What happens if I decide that I only want occasional coverage?

PETER: Well, you might be occasionally stupid, to be a little direct. Let me respond to that a couple of ways. The whole point of insurance is you don't know what's going to happy next. Let me actually distinguish two things. Again, I'm not an expert in Medi-Cal. How Medi-Cal works is if you're eligible for Medi-Cal and something bad happens—it turns out you're 24 years old, but you've got cancer. You go to the hospital. Coverage could actually be retroactive for Medi-Cal. It's not for the Covered California programs. So if you're young or old and say, "Oh, I've heard that a health plan can never turn me away, and I've even heard that since I'm an American Indian, open enrollment doesn't matter. So I'm great. I'll wait until something happens." They are taking a huge risk because what that means is to get into coverage, you need to complete enrollment. If you enroll before the 15th of the month, you can have coverage that starts the beginning of the next month. But after the 15th, your coverage will start the next month.

Now, if you think, "I'll wait 'til I have cancer and then I'll apply for coverage," you will have racked up a half-million dollars in bills. One of the things I'd encourage you—you often hear the young folks are the "young invincible." And I like to say, "Yeah, but they're not the young and stupid. If you show them what it will cost them to have coverage," even someone that's working some and then not

working some—that means they don't have much income, which means there's a huge financial support to make coverage affordable. So I think we need to educate them to don't be young and stupid. Thank you, Michael. Please, sir?

SILVER: Good morning. I'm Silver Galletto(?). Yesterday, CRIHB hosted a meeting and a lot of the tribal clinics throughout the state, north and south, met. We drafted a letter. We had tribes sign it. I'll just give you a summary of what it is.

"Dear Mr. Lee: We, the undersigned representatives of Indian Tribes Health Programs and Urban Indian Clinics and Indian Communities in California, do hereby request the decision makers of Covered California, to fully support and expedite the adoption of the tribal recommendations outlined in this letter. These recommendations are designed to improve the Covered California, system for American Indians and Alaska Natives, tribes, tribal clinics, Indian communities, and Indian urban clinics. We believe that the implementation and maintenance of the following recommendations by Covered California will enable tribal and Indian entities in California to better support and serve American Indian and Alaska Native patients and would help ensure that Covered California meets its unique obligation to Indian people in the state."

"Our first recommendation was to support the Definition of Indian Bill, recently introduced in the United States Congress, by issuing a letter to all relevant federal agencies encouraging them to also support this legislation. Our second recommendation was take a leadership role similar to the State of Washington's Health Benefit Exchange by mandating the qualified health plans offer to subcontract with all Tribal Health Programs and Urban Indian Clinics. Our third recommendation: Assist in ensuring Covered California's expedited and smooth adoption of aspects of the new state law regarding tribal Medi-Cal administrative claiming processing using the California Healthcare Eligibility, Enrollment and Retention System, CalHEERS. Fourth recommendation: Continue providing support to Covered California's Tribal Consultation Program. Implementation of these recommendations will result in expanded access to healthcare services for all Indians and increased revenue to tribal and Urban Indian entities. It is especially urgent to ensure that the definition of Indian is implemented to include a sizable population of Indians that the ACA was intended to benefit and protect. Increased access will decrease the morbidity and mortality of Indians in California. It is imperative that Covered California continue to convene meaningful tribal consultations and take action on requested tribal recommendations."

"We thank you and other Covered California decision makers for your attention to the issues outlined in this letter. We look forward to working with Covered California to implement and maintain support for the tribal recommendations within the structure of the state's health insurance marketplace. Should you require further assistance, please contact Mark." Then below we have signed by United Indian Health Services, Elk Valley Rancheria, Smith River Rancheria,

Yurok Tribe, Maidu Tribe, Greenville Rancheria, Santa Ynez Tribal Health, American Indian Health and Services, Inc., Santa Barbara Urban, Wiyot Tribe, Susanville Indian Tribe, Sonoma County Indian Health Project, the Cloverdale Rancheria, Tolowa Nation, Greenville Rancheria, Karuk Tribal Health Program, Ewiiaapaayp Band of Indians, and Riverside San Bernardino County Indian Health. Thank you.

PETER: Great. Thank you very much. I'll actually ask for an electronic copy, because one of the things I will do is not only take it myself, but share it with our board. It's good education and engagement for them, as well as engagement for us and our staff. I will, at some risk, respond quickly and immediately to quick reactions, working backwards from four up to one. We are very committed to this consultation process and will continue to build on what I think has been a successful consultation process. And it's not just the once a year, but it's ongoing the advisory committee I think has been vital, and we are very committed to that. The issue of tribal Medi-Cal—we partner very, very closely with the Department of Healthcare Services, which is the agency that implements Medi-Cal, and we're committed to continue partnering with them to make sure that Indians get all the benefits of Medi-Cal. But some things are their job, not our job, but working with them. We'll digest these in much more detail as well, but I'm just giving you a quick off-the-cuff so you can either say, "Are you crazy?" Or you at least know I heard you(?).

Third, working backwards, the issue of mandating participation of clinics with our plans—as you know, that is not our current policy. And it's something we'd review, but, quite honestly, my strong take is—I'm a data-oriented guy, and let's see how many plans have contracted without a requirement. Let's see where tribal members go without that requirement. Let's compare our experience to the State of Washington. That's my gut. We want to make sure that tribal members get timely access to care. That's the end we're looking for. So we're very big on measurement. We're very big on having information that we can use and review. In some ways, we have two states, Washington and California. And I talk frequently with the director of the Washington Exchange that each have a substantial number of tribes that have taken different approaches that I think are both philosophically the same. How do we make sure that tribal members get access to care and get good care in a timely way? We actually have an ability to sort of see how the different policies work out. We'll think more about this and absolutely engage in more discussion around it, but that's a leaning of where I am on that.

And the first issue is if this is support for a specific law that is being proposed—is that what this is? Is it a proposed piece of legislation?

MSPKR: Yes.

PETER: Covered California actually cannot lobby or take positions on bills. It's one of the things that we are supported by federal funds, and one of the restrictions on our activities is to not take positions on legislation. We do provide expert assistance in California to legislators that are working on legislation. But it's one of the things that we actually can't do. But we will look at this very closely and see if we can provide expert counsel and advice. But we cannot cross the line and actually take any specific positions on legislation. I very much appreciate the signers of this that spent the time and effort. We'll look at it with more care, but I wanted to give you my off-the-cuff on these. Very fruitful and appreciate your time on those, so thank you. Sir?

DANNY: My name is Danny Jordan. I'm from the Hoopa Tribe, Northern California. I can just tell you that any time anybody comes to us and says, "We're here to help," coming from Hoopa, we say, "Trust but verify."

PETER: Absolutely. You should. I'm a big believer in trust but verify.

DANNY: We're in that mode right now. But we're looking at this Affordable Care Act from really a couple of different perspectives. We have Indian Health Service programs, 90% of our employees are Indians entitled to Indian Health Service benefits. But they're also covered by the tribe's self-insurance program. Now, we're self-insured because we're sitting way up in Northern California, and not too many people or insurance companies are interested in traveling up into the mountains and insuring a tribe that's sitting up there all by themselves. So we have evolved into this self-insured status, and we don't know how to break that without going back into the same problems we had before we got into self-insured.

But my point is, we were looking for the trapdoor in the Affordable Care Act. We haven't found it yet. We see all upside, especially where we fit in as an employer, as the Indian Health Service program. Now, unless the Affordable Care Act benefits end up being reductions in Indian Healthcare Improvement Act budget, we have a concern about that. That should never be allowed to happen. But that's not what's on the table yet.

So my question is, and kind of the landscape of this meeting today—we are looking at it from multiple viewpoints, from the Indian Health Service program benefit—can and obviously will, the Affordable Care Act will actually be an enhancement of funding for tribal clinics. But as a self-insured tribe, we also provide insurance to our employees, 90% of which are Indians. Where do we have this discussion? When we look at it—and this is a discussion we're having back at Hoopa. When we look at all these options now, the tribe's insurance, the unemployed individual that now has options under the Affordable Care Act, the Indian Health Service money—this is a matter of us organizing for the benefits as opposed to trying to find problems with it. My question is: Are we going to have

that discussion here today, the tribal governments as employers? Because this has got some interesting things for us.

PETER: I'm not sure. I don't think that's on the agenda, but I would actually encourage you to organize yourselves around those tribal governments as employers. Where I would turn, if I were you, is to your brokers or agents that help you structure your self-insured program, and have those of you tribes that have self-insured programs together say, "How do we sort through this?" Obviously, you've done some of that tire-kicking, so to speak, and I totally applaud your note of "trust but verify." And along those lines, I noted at the beginning, this is a huge change to health insurance in America. There will be unintended consequences. So the fact that you're reviewing these in great detail, including looking at: How are you making sure that tribal clinics are not undercut? Right thing to have an eagle eye on. Absolutely.

The specifics—I don't think the conference organizers have breakouts of tribes as self-insured employers, but I would strongly encourage you to have those discussions. You're absolutely right. And also, if and when you find trapdoors, so to speak, let us know. Writ large, there are elements of the Affordable Care Act that are far from perfect. There's elements that Congress should revise in future years when they start becoming functional—that's Congress, which may be a long time. But we're now implementing the law, which means there will be opportunities to do cleanup. So I would encourage you to think about issues that are, as you say, trapdoors, that may be in the law or may be in how it's implemented. And we'll partner with you on either of those. Thank you very much. Sir?

RICHARD: Richard Mechas(?), San Pasqual Band of Mission Indians, San Diego, California. The CFO of the tribe, I'm charged with getting insurance for our tribal members. We have 206 tribal members. So we're considering a group health plan. I was on CoveredCalifornia.com, and your insurance plans are very attractive. They're affordable and there's a lot of selection.

PETER: Let's just stop there then. I'm just kidding. Sorry.

RICHARD: Getting a group plan is more expensive because tribal members, they're older than an employer group, and they have health problems, and it's more expensive to buy for the tribe. I'm wondering, is it your advice that I should have my tribal members enroll in CoveredCalifornia.com? The plan look great. Or is it just—are they going to have enough physicians that are going to be able to take care of them? Or should I take the safe, easy route and enroll in that group insurance plan that's very expensive, and I know that they have carriers because they've been doing this for year—Anthem Blue Cross, for example. I know they're on one of the insurers here, but I'm just worried that I'm not going to have real coverage for these individuals when January 1st comes around, and then I'm going to get

terminated because I recommend CoveredCalifornia.com and it didn't come through for me. [laughter]

PETER: Well, two things. One, the two of you should talk. The issues about how you as employers offering group coverage—there's a range of issues.

RICHARD: It's for the tribal members.

PETER: Both for members or—the issues are the benefits and pros and cons of group coverage, whether it's for employees or tribal members. They're similar issues. I would say, by and large, the concerns you raised I would toss right out the window, quite honestly. So let me go through a couple of things. The health plans that you can get through Covered California and in the San Diego area are the best plans in the market. For instance, it's Kaiser, it's Blue Cross, it's Sharp. I think Health Net's down there. I don't have 'em all memorized, but you know them; you've looked at them. And the networks that they have of physicians, I want to note, is most of them—with regards to the network, they cannot be on our shelf if they don't have enough doctors to take patients today and if they don't have enough doctors across the full range of specialities, that if you have something that goes really bonkers bad, you're gonna get to the best specialist that you need to get to. There's been a lot of brouhaha around, "Are there networks? Is it second-class care?" The networks that we contracted with were to assure that every plan on our shelves has doctors today ready to take patients, has hospitals in reasonable distances, etc.

I think that the concerns you've addressed wouldn't be the concerns that I would have. The same plans or better. Maybe not the exact same networks. So the thing I'd counsel you to is some of the health plans have different networks for their group products than they do in the individual market. The issue of, how big is the network and what's that work? That would be a factor to look at. But I'll tell you, we are going to be on it like a dog on a bone making sure that every plan in Covered California provides accessible, ready access to doctors when patients need them. This is another area where the issue of trust but verify—I love that note—is I hope and expect you'll work to hold us to account. Before they fire you, they should be firing me. We're out there. Our vision is people getting care. We will be looking at this all the time. If it appears that a plan can't handle more patients, we'll shut that plan down and say, "Sorry, we aren't going to sell more business to you until you get your stuff together and add more physicians." We are quite confident that all the plans will have a solid network of doctors. Thank you, sir.

JESSE: Jesse Montoya, CEO from Riverside/San Bernardino. You were talking about how people have been going to the website and enrolling, and 70% really get it and the 30% don't get it. I just want to indicate that I'm going to be talking briefly about the 30%.

PETER: Great. That's what we learn from. I love that.

JESSE: So one of the things is we sent nine staff people to the training in Temecula, the southern part of California. What our staff came back with were some concerns, and so they outlined those, questions and concerns I'll give to you and your staff here today. I think the biggest issue that came out of it was that while the people maybe understood the program, they really didn't understand what the ramifications were or the linkages to the Native American community. So they didn't understand the waiver process. So our staff put these questions together. I don't think they really understood that. Now, I know CRIHB is going to be offering classes, so we're going to send some staff here. But for us to send nine staff up here as well is somewhat problematic that we still do it for the certified enrollment counselor program.

But just to give you a sense of it—and I don't want to take a lot of time—does the Native American exemption apply to enrolled tribal members? Are Native American descendants going to be exempt? How do Native Americans prove that they are Native Americans if they're not federally qualified? Will there be a class through Covered California offered for Indian programs only? Which we know CRIHB is going to offer that. Are the Native American programs going to provide services to outside non-Natives? Some of the reservations have stations where you can't actually go on the reservation unless you have some specific business or you're actually a patient of our system. Are California State recognized tribal members exempt from signing up? Will gaming revenue be considered as part of income? When applying for Covered California, do the plan automatically include dental and vision? It sounds like you talked about it's going to be covered for children, so we can take that back, and I'm sure we'll spend a little bit more time on that. And then, Riverside/San Bernardino County Indian Health System has not been contacted by any of the insurance plans in our area.

So I just wanted to share that these are some of the things that came from our staff. Now, the other thing that came up in our meeting yesterday is that when some of us have contacted our Social Services Departments with the various counties—and there are 58 counties in the state—they may not clearly understand how this program will apply to Native Americans. I think there's been a lot of work done, but I think there are some areas that your staff will want to take a look at.

PETER: Let me actually just quickly go through. The answers are: yes, yes, no, no, yes, no, and we're working on it. These are great. I appreciate the questions. The thing that I would note—there's a couple. One, we've been working in very close partnership with CRIHB. But also, one of the things to recognize is that, on the one hand, we've been working for a couple of years. One the other, two years ago, when I started at Covered California—David how many of us were there, seven people? And we've been getting up to speed very quickly. And part of getting up to speed very quickly—back to my absolute ownership of

imperfection—some of our training has not been as complete as it should be, and we're doing catch-up.

For instance, we're developing, as part of what we are calling In-House Covered California University. Learning is an ongoing thing, including developing new materials. And we're developing fact sheets not for consumers so much, but for people that work in the 58 counties, for the certified enrollment counselors. And one of the things we have track, and we'll work with CRIHB on this, is a fact sheet on issues very specific to exactly these sorts of questions. Again, not so much for consumers, but for enrollment counselors, people on our phones. I can tell you, we've got a great staff answering the phones. And my bet is if you asked all of these questions, or selected five of them, you wouldn't get the same answer from every single person right now, today. So we need to work on that, and that's one of the things we're doing as part of our improvement. So you flagging these questions is incredibly helpful, and we appreciate it.

KATHY: Hi, I'm Kathy. I'm from Redding Rancheria. Just as kind of an FYI, I met this week with some local people in Shasta County. From what we were being told, the two plans that are offered that far north, one of them is on the website and it hasn't even been approved by the State of California yet. So how can we build trust if that's the case and if that's what we're being told. So we have Blue Cross and Blue Shield, and I can't remember which one was which now. But one of them says it's one there but they're still not totally approved, so you can't see the benefits and the details behind that plan. That causes some trust issues there.

PETER: I'm very confused by that because both those plans are licensed and approved.

KATHY: By the state?

PETER: By the state.

KATHY: Okay, because that wasn't what we were told, and so that—and just to let you know, Social Services, insurance agents, and certified enrollment counselors were all in that meeting, and they all were telling us the same thing. So you just might want to look into it.

PETER: Okay, we absolutely will. And this is a great example. Shasta is a rural area and is one of the few areas that has two plans that are part of what's being offered. San Diego would have four or five, etc. But absolutely it's my understanding that both are approved by, in those cases, the Department of Managed Healthcare, are up and running, have standard benefits, have contracted clinicians, etc. I would also note—and one of the things that I—and Leah will speak to this some more. If your tribal clinic has not been talked to at all by a health plan, I'd like to know that. Let Leah know that instead of me. But this is one other thing. Back to the note of right now we are not requiring, but we're doing a lot of encouragement. And we have done matchmaking, saying, "Have these discussions. Work

together." So the note of saying, "No one's reached out to our clinic yet," we like knowing that and we want to know that. Leah will speak to that some more when she talks about some of the network and plan-related issues.

MSPKR: When we had our advisory meeting, we brought that up about six weeks ago that we had not had any outreach, and we still haven't had any outreach.

PETER: Okay. Again, we are a constantly improving organization. Six weeks ago was October 1st, which was kind of a busy time for all of us on lots of issues, so I'd appreciate—continue to write us and provide suggestions. But also in the frame of what's happening generally, which is a lot. With that, Mark, I really appreciate you having me here and joining us in this process. Because, again, our success is your success. Making sure your tribal members get access to timely care. That's what we look forward to working with you together on. So thank you very much. I hope to come back at the wrap-up time today. But if I don't, I really appreciate being here now. Thank you. [applause]

MARK: Thank you, Peter Lee, for providing those opening remarks. And thank you, tribal representatives, for working to stick to the timeline. One of the things that we've taken note of over the course of the last several years in working with Covered California, a lot of the tribal reps are very enthusiastic about this work, about the leadership of Covered California to work collaboratively with the tribes and the clinics to ensure that Indian patients in California, all of them, have access to affordable healthcare coverage. As we're working together, the tribal reps, we sit around and we talk and we contemplate and we figure out, "What we can do to assist Covered California?" Certainly, Peter, you've been instrumental in this partnership.

One of the things that the tribal reps noticed is that, well, Peter's working quite well with the tribal representatives, and he wants to work with us going forward as well. And so some of the tribal reps said, "Well, then he has a couple of choices. One, if he wants to continue to work with tribal reps, one, he either needs to grow long hair—"

PETER: When I was younger, it was down to here.

MARK: Like many of the tribal fellows have, or two, he needs a necklace. So, Peter, the tribal reps give you the option of whether or not you'd like to grow your hair long—it's up to you. [laughter] But certainly under tribal custom and Indian law, you're not allowed to not accept this gift. So, on behalf of the tribal representatives in this room, my particular tribal advisory committee, the California Rural Indian Health Board leadership, we present this necklace to you, Peter Lee. [applause]

PETER: I am so touched and honored. We'll see. Next time I see you, we'll see how long the hair is. But you'll definitely see this necklace on when I see you next, and I

am so appreciative. The spirit of partnership and doing this together is very dear to my heart. And it's something that clearly you have passion for. That we share. So we're on this road together, and I very much appreciate this, Mark. Again, I want to say thank you to Jim. I know Jim's still on the board, and everyone's going to retire now, but it's really been such a pleasure working with both Jim and Mark. You've got good leaders to partner with, and we look forward to working together with you. So thank you very, very much. [applause]

MARK: Next, it's my privilege and honor to introduce Cynthia Gomez. She is Governor Brown's tribal liaison. She is a citizen of the Tule River Tribe. So without further ado, I'd like to call Cynthia forward to please provide some additional opening remarks on behalf of Governor Brown. [applause]

CYNTHIA: Good morning. Good morning! I know there's Starbucks out there, and that Starbucks is really some potent stuff to keep us awake. First, I want to say thank you for having me here again. You probably get tired of me sometimes showing up, but I'm always pleased to be here because it gives me the opportunity to listen to what the concerns are when I'm able to attend. And also it also gives me the chance and the opportunity to thank all of you. Because, quite frankly, the healthcare in our Indian communities would just not be where it's at, or improved, without all of you out there working so hard and being the front people in our communities to better healthcare. So I'd like you to give yourself a hand. [applause]

I know Jim Crouch has retired. I've said this many times, and he has been a very esteemed leader in our health services in Indian country. And I am so pleased to see that he is continuing to work with Mark. I know Mark's going to be a fabulous director. I've worked with him for the last couple of years. He's very thoughtful. He's very articulate. And he has the passion to improve healthcare in our Indian communities. That's one of the main ingredients we need when we have leaders in our tribal communities.

I'd also like to give recognition to our honorable tribal chairman, vice chairman, and council members. Would you please stand? I know we have a couple here. Excellent. Thank you all for making the trip. [applause] Sometimes our state leaders don't recognize that the amount of work and responsibilities and obligations that you have at home. And so coming to a session like this is pretty significant, because it takes you away from all the other duties that you have at home. So I'm really pleased to see that we have as many tribal leaders here as we do, particularly because it's a consultation session.

I also want to give recognition to all of our esteemed health professionals. And I know many of you out there have been doing this for a long time. Without your dedication and your passion and your commitment to your own tribal communities, we just wouldn't have the kind of healthcare that we have today. We have come a long ways in our healthcare.

I grew up on the Tule River Indian Reservation. Some of you have heard this story before and say, "Oh, there she goes again." But I've gotten to that status where I get to tell my walking in snow ten miles position, you know? But really, I grew up on the Indian reservation, and we didn't have a health clinic when we first started. I remember our family having a lot of healthcare issues, without having the ability to get the proper healthcare. And some of that had some long-lasting effects. The first clinic we had was up in our adobe building that we used for a chicken coop and storage and everything else. And we had to clean it up real good. And we were just thankful that we were able to have a physician come up once a month. So we've come a long ways. I went home a couple of weeks ago, and I went over to the Tribal Health clinic, and it's a beautiful building. There's wonderful healthcare, and a lot of dedicated people to make sure that there is that healthcare for our people. So I'm really pleased to see the improvement over the years.

Governor Brown signed Executive Order B1011 back in September of 2011. It did a couple of things. One, it created my position. The other thing it did, it gave not only permission but mandate to all of our state agencies to do a better job in communicating, consulting, and collaborating with our tribal communities. And that's what I see happening here today. I was here last year, when you had your first consultation session, Covered California had their first consultation session. And I was very pleased to see the kind of turnout we had, the comments that we had, and the response that we had from Covered California. And, quite frankly, I heard from a lot of you that were at that first consultation session, and many of you said, "You know, you need to make sure that this kind of consultation happens in other agencies, and we need to have this kind of consultation happening in other areas of California. And that's one of the things I'm trying to make happen. I just want to applaud Covered California for your efforts to do a job that has been well received to improve health services as well and get that coverage out to our tribal communities. So thank you very much.

I received an email a few minutes ago, and it was from Herb Schultz. Apparently, there were quite a few health clinics that were just announced being funded for additional funding to help with the effort of doing outreach for tribes and other health clinics to [..?..] culturally competent, quality primary healthcare services. I couldn't bring up the list, so I don't know who was actually funded or not. All I know is that there were 46 health clinics that were funded with over $30 million dollars. That's to help cover the 42% of our three million people in California that are uninsured. I was really glad to see that happening, that there's still an effort to get more funding into California, to make sure that we continue this effort, that we have a good program and we improve the services. So I applaud all of you.

Before I go, I also want to introduce someone who's very important to me. She is my chief deputy. Heather Hostler, would you please stand? [applause] Heather is from the Hoopa Indian Reservation. I hired her about a year ago, almost to the

day. And it was one of the best things I ever did because she keeps me sane, and that's why she's so important to me. But she actually helps me out with quite a bit of the research and all of the duties that we have in our office of two. She's going to be here the rest of the session, and we'll collaborate later on to look and see if there are things that not only we could be more aware of, but also if there's something that we're going to be charged to do in our office. And we'll also check in with many of our leaders, as well as CRIHB.

Thank you very much. I wish you a wonderful consultation session. I'm glad that you're all here. I wish you a safe ride home as you make your way back to your communities. Thank you. [applause]

MARK: Thanks, Cynthia. I know you know this, but it's really very helpful to know that you are in the governor's office, there for the tribes, the tribal clinics, and the Urban Indian Health clinics as well. We're very pleased to also work with Heather Hostler in similar regards. Your leadership in the tribal office there definitely assists in the healthcare arena, and I know that you're tasked with multiple other issues, education, housing(?), Department of Corrections, so on and so forth down the line. So the fact that there are two staff that are working in all of those agencies and all of those departments and all of those offices, working to ensure that consultation is carried out—I just want to thank you for your diligence in that effort. And also express to the folks in the room that I believe that the governor's tribal liaison office needs our support. Maybe our tribes could send resolutions and additional(?) support staff. We could maybe talk about that on the side. I'm sort of moving into the advocacy realm, but I'm not supposed to do. There I go again, being an advocate.

That being said, I am equally pleased and honored to introduce Vicki Macias. She is an outstanding Cloverdale Rancheria representative. She is one of our leaders on the Covered California Tribal Advisory Committee. Vicki wears multiple hats as well. She also serves on the California Rural Indian Health Board of Directors. Ladies and gentlemen, without further ado, I give you Vicki Macias to provide the tribal report on Covered California. Thank you. [applause]

VICKI: I was trying to make them hurry so I could say what I wanted to say before Mr. Lee left. I'm a little bit stupid and I am a little bit crazy, but the first 45 minutes actually felt like a consultation because we had dialogue back and forth. No offense to his people, his staff; it's just sometimes when we have that back and forth with the person who can make the decision, it makes us feel like our presence here is worthwhile. I wanted him to hear that, but he walked out the door. That's as Cloverdale Rancheria, because I have something to say from the advisory.

I was lucky because I came to the meeting today. I'm taking the spot of someone else. I'm not a reader, just so everybody knows; I like ad lib. They have something very nice here that I want to report. On behalf of the Tribal Advisory Work Group

to Covered California, we want to welcome tribal leaders, Indian Health Program representatives, as well as leadership representing the State of California to the Second Annual Covered California Tribal Consultation.

We are fortunate to have established a positive partnership with Covered California under the leadership of Peter Lee. I want to thank him for his guidance in ensuring Covered California develop a tribal consultation policy to guide the organization's work. Tribal consultation is paramount to ensuring successful government-to-government relationships. In a presidential memorandum in 2009, President Obama issued the following statement: "The United States has a unique legal and political relationship with Indian tribal governments established through and confirmed by the Constitution of the United States, treaties, statutes, executive orders, and judicial decisions. In recognition of that special relationship, pursuant to Executive Order 13175 of November 6, 2000, executive departments and agencies are charged with engaging in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications and are responsible for strengthening the government-to-government relationship between the United States and Indian tribes. History has shown that [..?..] include the voices of tribal officials in formulating policy affecting their communities has often led to undesirable and at times devastating and tragic results. By contrast, meaningful dialogue between federal officials and tribal officials has greatly improved federal policy toward Indian tribes. Consultation is a critical ingredient of a sound and productive federal/tribal relationship."

Unfortunately, in the State of California, we can cite examples where tribal consultation has not occurred, and our Indian people have suffered. For example, the federal termination of over 30 tribes occurred without proper and adequate consultation with tribes. This has lasting devastation implications of our Indian people. On this issue, tribes have worked to right these wrongs and hold the federal government accountable for its actions in solving this problem to the benefit of tribes.

In 2012, tribal leaders met with Covered California staff and made the following recommendations: Create a mechanism to identify qualified Alaska Native and American Indian—we're used to just saying "Indian people." We don't distinguish because you're from Alaska, you're different. I just wanted to point that out. But for your benefit, we're going to use American Indian and Alaska Native. See why they don't really let me read? [laughter]

I am pleased to inform you that this mechanism is currently in the system and will be demonstrated by Covered California [..?..]. Develop a payment system to set up up-front group payment mechanism, similar to the mechanism used by some tribes to enroll members in the Medicare prescription drug program. This capacity has not been built, nor are there any Covered California regulations yet. Tribes are

looking forward to working with Covered California to develop this payment system.

Three: Create a mechanism to ensure qualified American Indian and Alaska Native that the appropriate cost-sharing calculations are built into the system. I am pleased to inform you that this mechanism has been built into the Covered California system. However, there are outstanding issues surrounding households that include members of federally recognized tribes and non-members termed "mixed households." Tribes are looking forward to working with Covered California to resolve these issues.

Four: Ensure the Covered California system will identify and exempt certain types of Indian income that under the Affordable Care Act should not be calculated into the gross(?) income. The Tribal Advisory Work Group has not seen the system to know if this is sufficiently addressed. We have reviewed the paper application and aware that the appropriate income questions are addressed. We are looking forward to continuing to work with Covered California on this part of the system.

Five: Covered California needs to facilitate full participation by Indian Health clinics, tribal clinics and urban clinics, and covered programs, including designated ITUs as essential community providers. Covered California needs to maintain openness to modify network contract terms to accommodate the unique circumstances of the federally created ITU system. The issue of ITU as providers remain and outstanding issues. The Tribal Advisory Work Group has addressed this issue at length with Covered California and will continue to recommend Covered California mandate the qualified health plans offer contracts to ITU in California.

Six: [..?..] to include tribal and Urban Indian entities as navigators in the exchange. The work group looks forward to working with Covered California in the implementation of the navigator program.

Seven: Covered California needs to provide planning, implementation outreach and other grants to tribal organization. Covered California issued a request for proposals to develop a tribal community mobilization program. This request was responded to by California Rural Indian Health Board and has been successfully awarded to CRIHB.

The Tribal Advisory Work Group is pleased to report that several of the tribal recommendations submitted to Covered California in 2012 have been addressed. However, there are some outstanding issues that have been brought to light by the work group, as well as other tribal leaders. The Tribal Advisory Work Group has convened four meetings in the last year and addressed various issues concerning unique Indian provisions of the Affordable Care Act as they apply to Covered California. We look forward to working with Covered California to work towards

evaluating the health issues of all Indians in California. And I apologize—I'm not a reader. That's that little bit of stupid and craziness of me. I like ad lib. I like to talk to the people, you know? Thank you guys for being patient. [applause]

MARK: Thank you again, Representative Vicki Macias. That's really an integral part of this partnership we're doing, to have a representative who serves on the Covered California Tribal Advisory Committee provide a report out to all of the tribal representatives that are in this room, noting issues, working to resolve issues, so on and so forth. So thank you for providing that official report.

Next we have on the agenda at 10:45 sharp—we're a little bit early—Leah Morris, and she's going to provide a presentation on qualified health plans. We've talked a little bit about that this morning, quite a bit about it yesterday afternoon. Is Leah read to come forward and present the material? Without further ado, I give you Leah Morris. [applause]

LEAH: Well, thank you for having me here today as part of the Covered California team. I also wanted to point out a couple of other folks on the Covered California team. Molly Tamashiro, here in the front row, sitting with me, is our plan management liaison to the policy team, who works with all of the issues regarding Native Americans and Alaska Natives. She's happy to also be here today and gather information and learn your questions. I wanted to also point out that though Peter has left, there are other people here today who are senior leadership at Covered California, David Maxwell-Jolly for one. So we are still here, present to hear all of your concerns and issues. Peter will be back later, but you definitely have the attention of Covered California.

So I am with the plan management team. My name is Leah Morris. And I'm also a provider. I'm a nurse practitioner, and I work a couple of days in hospice. So I am not always at Covered California, but I do my best to keep in touch with you all and understand questions and concerns. But that's another reason why Molly is here today, to make sure we stay on top of your questions.

As you know, there are 11 health plans that are now under the relationship with Covered California, called "qualified health plans." You may hear me use the term "QHP." That's sort of our in-house shorthand for these 11 health plans that you have the opportunity to potentially enroll in, depending on geographic region where you're located.

FSPKR: Do we have that in our packets?

LEAH: I'm going to get to the interactive part of the presentation. Thank you for the question. We'll get to that in one second. And I appreciate the fact of not just being a reader. I'd rather have us talk together. Let me just hit a couple of points here. As we've talked about quite a bit, the idea of affordability is important, the idea that there are no or low-cost health plans available to your communities is

important to us. We also want to talk about access to care, that having enrollment into these local and statewide plans is a way for us to have statewide health insurance companies that offer approved networks. You asked about something in Shasta. All of the networks have been approved by the regulators, Department of Managed Healthcare. So if there are specific questions, we should probably follow up on that and make sure we understand what your specific questions are. But those plans have arranged a network of providers that includes medical specialists, includes hospitals, includes other services that have been approved. So if you have questions, we need to make sure we follow up on those.

Also, coordination—I want to point out that these plans have committed to coordinate care with your communities, with other facilities, with facilities outside of your region if that's necessary, if there's a need for care that's possibly at a tertiary medical center or a high-specialty type of service. Those plans have committed to coordinate care with all of the enrollees.

I want to start to get us some really concrete information about how this program is working and the health plan relationship. It's important for individuals to understand that there are what we call 19 grading regions. So if you look at this map, you might start to look at where you're located, where your clinic may be located, and understand which region you're in, because that is important for understanding which qualified health plan is available. I'm just going to take your attention to Region 3, the blue region in the middle. That's where we are today. That's the Sacramento, Placer, El Dorado and Yolo County region, so it's a four-county region. You're sitting there right now.

And here's the interactive portion. You all should have at your chair a copy of the health plan booklet. I'm going to ask everybody to take a look at that health plan booklet and turn to page 12, where you will see Region 3. Now, obviously, I'm just talking about where we're sitting today; later you can look up your own region of where you are. But if you look at Region 3, you see that the health insurance plans that are available in that region are Anthem, Blue Cross, Kaiser Permanente, and Western Health Advantage.

I noticed the Chapa-De folks were introduced earlier. I know also that there's Sacramento Native Indian Health on J Street here in Sacramento. These are the health plans that you would want to be focusing on talking to, in terms of which networks are being offered to the residents of your area. So as you're learning about what might be an opportunity to talk to a health plan. Be sure you take a look through this book and make sure you understand which plans are offered in the area where you're serving your clients.

The term was brought up a little bit earlier about "essential community providers," or ECPs. The concept about coverage for people who are medically underserved, low-income individuals. The Affordable Care Act set a requirement that qualified health plans would include these essential community providers to

serve predominantly low-income, medically underserved people. In the ACA, there was a reference to 340(b) providers. Some of you may be familiar with the 340(b) program. It's a program that sets up some subsidy for pharmaceutical programs, some discount subsidies. Entities that qualify under the 340(b) program are non-profit entities. So that was a starting point for what would be considered an essential community provider.

In August of 2012, the Covered California board adopted a policy that expanded upon that definition of 340(b) in terms of essential community providers. We looked beyond, into other types of providers that might be serving the low-income, medically underserved population. And, in particular, we identified very specifically the Tribal Indian Health Programs and the Urban Indian Health Programs. I'm going to say that for the most part those entities are 340(b)s, but we felt it was important to specifically identify those types of providers as essential community providers so there would be no confusion about whether we understood their relationship to serving the low-income, medically underserved population.

Jill Marden(?), I think who might've just left the room, was critical in teaching me about the different clinics and the different provider names and addresses and how we could list those providers. We made sure that we were comprehensive in understanding [..?..]. You'll see a document—yours is blue; mine is green. This is what we believe to be a comprehensive list of the Native American Alaska Native clinics throughout the state. We'd ask you to take a look through this and give Molly any corrections. We worked on this with Virginia, I believe, and we've tried to make sure we have a comprehensive list of contact people for each of your different sites and your satellite sites. So please take a look through this and let us know if we have any mistakes on this document.

In our essential community provider discussions, we required a few things. We required that each of the networks would have 15% of those 340(b)s in their networks. We also required that they had to demonstrate an array of types of providers. So it couldn't just be a couple of hospitals. They had to have clinics. They had to have other providers who were available geographically in the region. And we did also require that they had at least one essential community provider hospital in their network. The list of hospitals was part of the 340(b) list, and we also turned to the California Disproportionate Share Hospital list, the DISH list that's maintained by the Office of Statewide Health, Planning and Development. Some of you may recognize that list. There are a few hospitals on that list that are not 340(b) providers. We wanted to be sure that we included providers who see the low-income and medically underserved populations.

So what have we done in terms of working with the Native American community and trying to facilitate and support contracting with your providers? As I said, with Jill Marden's help and folks from CRIHB, we specifically got a list of the Tribal and Urban Indian sites and we included that in our solicitation that went

out last November so that when the health plans were bidding—there were 33 plans that bid—they all had the information about the health centers that were part of the ECP program. Since that time, I personally, and Molly, have distributed this list to our qualified health plans to engage them in contracting with the Native American health centers. We've twice distributed this list, along with the addendum, and encouraged those different clinics to understand the addendum and to use the addendum in their contracts, if they're looking at different relationships, and to under how the rules apply to them in terms of the Native American community. As I said, we've also twice distributed the addendum. So we're trying to learn together about some of the rules that might apply and working through some of the information that the addendum helps clarify, in terms of payments, in terms of requirements around malpractice insurance and the fact that there is not a requirement for that. The fact that some of your providers are licensed in other states; they come to this state so that they don't have to have a license in California [..?..]. So we're trying to make sure that we work with those health plans to understand some of the special attributes of your provider offices.

We also invited some of your representatives to a meeting in September that we held with our health plans. At that meeting, we had the chance to talk about some what I'll call "pithy" issues related to provider relationships. The topic of grace period and the topic of provider network adequacy and essential community provider relationships came up. We had a discussion with our qualified health plans about these issues, who qualifies to be an ECP and why an ECP is important. That's not the first or last time we will talk to our plans about that, so more down the line.

We also asked our qualified health plans to provide us a list of contracted clinics so that we could put it onto our provider director, when the provider directory is ready to be populated with clinics and facilities. Some of you are aware of the online provider directory right now. At the current point, it's listing strictly physician names on the directory. There have some of those [..?..] about some of the things to get loaded on our provider directory, and we are definitely working through and trying to improve the online provider directory so that we'll list clinics and other facilities. We've asked for the health plans to give us that information, which is another way of putting pressure on the health plans to look to your facilities and work with your facilities.

A couple of things about what we might be able to do together to improve contracting, because there are some concerns, and we've heard them today, about the idea about needs for contracting between your clinics and our health plans. Before we leave today, we have a list of contacts—I call it "the grid." I put together a grid of qualified health plan contacts, and we'll hand it out today before you all leave, but I'll just pull it out here and give you a quick visual. It's on a Covered California memo format. We will distribute it today at lunchtime. This is going to give you the name of the person at the health plan for you to contact and

talk to about a contract. Again, I would ask that you go back to the booklet, look at your region, understand which plans are serving your market, and then contact the individuals in this list. I will also say that I have spoken to all of the individuals on this list about working with you and putting contracts in place, and would reiterate what Peter said: We want to hear from you whether you're having any questions or concerns in reaching out. I've talked to a variety of the folks about doing such a thing as a conference call with the clinic and the health plan representative if you're having trouble getting in touch with one another, and I've had commitments from each of the plans to engage in discussions with the Native American and Alaska Native clinics. So we want to move forward with that.

Another thing that we are learning about, or I am learning about—and Katie Ravelan and Jessica Abernathy(?) are really helping—is we are learning more and more about what the out-of-network relationship is. So we heard earlier today that Native Americans can continue to get services at the clinics that are in their communities, and there is not a problem with that. So at this point, if you don't have a contract and that's an out-of-network service, we need to work with our qualified health plans to understand: What is their responsibility to you, for a member that's enrolled with one of them and goes to one of your clinics, and you're an out-of-network clinic? Obviously, the member is entitled to go there. We need to make sure that we educate our health plans about what's expected from you all in terms of referral to other services, in terms of compensation, in terms of any authorization for procedures, etc. So we've got some more work to do on that. We look forward to you all teaching us a bit more about your expectations in that arena.

The provider directory is going to be an ongoing thing. I want to set expectations here. The online provider directory is not going to be fixed in a couple of weeks. So please understand and work with us, as we are working to reprogram some of the aspects of the online provider directory to do the displays as you all would like it to be. It's coming. We have a lot of really talented people working really hard to get it, but it's not going to happen in a few weeks. So keeping your expectations reasonable or working with us on that will be important, because it's a challenge that we're trying to resolve, and a lot of people are working hard on it, but it's going to take us some time to do that.

Katie and Jessica and I were talking about the idea of possibly facilitating a meeting with the qualified health plans and representatives of your clinics to see whether we could help move some of these discussions along. I know that you have the Tribal Advisory Work Group meetings. We thought that maybe at your next upcoming work group, we might do something like that. I will tell you that some of the representatives from the health plans have attended other similar meetings with some other parties that were interested in having dialogue and having us facilitate some dialogue. So I've talked to some of the health plans about that. They've agreed to participate in a meeting like that. So we need to

kind of figure out how we would do that, and what would be a good timing to do something like that.

There are very strict rules around what can be talked about in public dialogue. We had a meeting with a group of physicians, asking some of the health plans very specific questions about the terms of the contract, payment rates, etc., etc. The health plans cannot answer those questions in group settings. That potentially can be construed as price setting or anti-trust. So if we get together and facilitate you into a meeting with our health plan representatives, they will not be able to give you an absolute specific answer to possibly a pricing question or some credentialing question, or some other specific thing. So please don't think that they're being resistant or difficult. They're trying to work within the laws that they have to work with, in terms of what they can share in a group discussion. The idea would be to get you together to meet the people, understand if you're in a region that's served by Anthem or Blue Cross, etc., and that you know who some of the contacts are. And we'd do what we could to facilitate the relationship there.

I think the last point that we wanted to talk about was—I think Peter raised the point, which was potential changes coming down the path for future contracting and our model contract. The model contract is the document that we hold between Covered California and our qualified health plans. Generically, we call that the model contract. The variety of terms that are in that contract have everything to do with their relationship with Covered California, how they enroll people, what are the quality requirements, what are the telephone answering pick-up timing—a whole host of things between us and the qualified health plans.

We've had some additional legal review. I know that there has been some request to have the addendum as part of our model contract, the Indian Addendum as part of our model contract and require that qualified health plans would use that addendum when they contract with Indian Health Service clinics. We have been told by our legal team that that would be acceptable and that we could do that. So we anticipate in 2015 putting that into our model contract. [applause] I'm glad to hear something worked [..?..]. I think that's probably it for me. Questions about our qualified health plan program?

MSPKR: I was looking at the plans that are being offered in our area, and some of our staff and myself were having a discussion a couple of days ago. We were doing it in relationship to another issue, where, if it's a PPO, it's pretty straightforward. The plan owns it. So if you pull us together and you facilitate a meeting, that part of it will go really well. But in Riverside County, I saw that we also have HMOs. One of the concerns that came up in our meeting is that the IPAs really are the owners of the HMOs. So will they be at those same meetings, the leader of the IPA in a certain area? Or is that even on your radar screen? And do we have to do more research and bring it to you?

LEAH: That's a good question about the model of the health plan. Some of them are PPOs and some of them are HMOs or EPOs. With the IPA model, where the health plan delegates out to the IPA and then looks to the IPA to develop the network under them, one of the things that we are talking about with our qualified health plans is we need to educate the IPAs—the independent physician associations, for those of you who don't know IPA—to talk to those IPAs about potentially subcontracting with your organizations. Because ultimately the patient gets signed to the health plan and then assigned to the IPA. And so if that patient goes to your clinic, as they're entitled to do, a part of that claim payment would be the responsibility of the IPA. We need to the IPAs to understand our relationship, Covered California, is with our qualified health plans. So that's who I can somewhat direct to come to a meeting. We need to work with them to educate their IPAs. I do know, particularly in the Medi-Cal world, in Medi-Cal managed care, there's been a lot of work with IPAs and understanding about working with clinics beyond the level of the IPA. So I think that we can build on some of those relationships.

MSPKR: I guess my other comment is that it's nice that you raised those points. But I think that when you take a look at Peter's opening remarks, how he talked about the goals of Covered California, our concern is that the qualified health plans or the IPAs are not really mandated. They're encouraged. But when you take a look at the volume of patients—and taking his statistics, there's four million people that potentially could qualify. That's about 1.7%. Native Americans represent about 1.7% of that total four million. But if you look at the patients that are going to be subsidized, the 2.6 million, that represents a little bit more than 2%. Because we're a very small portion of the overall pool, this is not something that they probably are going to want to spend a lot of time on. So I think that's one of the reasons why we really need to have language in there that would mandate that they actually have to contract with us.

You've already provided in your documentation a provision where they have to contract with 15% of the community providers. And under managed care they have to contract with at least [..?..] QHC. So there are provisions that have been established in managed care and now here. But I think, in my mind, it needs to be mandated because of our small numbers and our different responsibilities and the different relationship to state government. It should be mandated that they contract with us.

LEAH: Thank you for sharing your thoughts. We appreciate it.

VIRGINIA: Hi Leah. My name is Virginia Hedrick, Associate Health Policy Analyst at the California Rural Indian Health Board. My question is in regards to the September work group advisory meeting. Andrea Rosen had brought a document to the meeting that we believe, in how she communicated, was a list of ITU providers. The tribal leaders present at that meeting, as well as Tribal Health clinic directors, requested a copy of that list. I followed up several times, and Molly has been

really great in working with me to look at the provider directories. Obviously, there are shortfalls in it. But I do know that there was a document in her hand at that meeting that was requested by tribal leaders to have a copy of that. When will that document be available, and what is in that document?

LEAH: So that document was put together from the solicitation materials that were submitted by 33 health plans in February of 2012, when we asked all bidders to submit to us their essential community provider networks. So for purposes of some internal understanding about where things were standing with contracting, I asked Molly to do some analysis of what had been submitted in terms of being contracted as essential community providers. So we created a CRIHB list of contracts between the plans that we were aware of for purposes of our discussion back in February. Since that time, I'm very aware that the qualified health plans have been doing a lot of contracting. We can talk about what your experiences are, but I, for example, have been on the phone with Blue Shield, Hugo Flores, and he's the name on the list you'll get. And Hugo has been—pretty much, he tells me he's got almost all the different clinics on the list contracted. Now, there may be different people talking, but he's telling me that he's actively working on contracting with those plans.

I had Health Net on the phone the other day. We talked about their contracting activities. And one of the things that Health Net raised is that they're seeing that American Indians are choosing their plan and enrolling into their plan. So they're very aware that those members will be part of their enrollment, and that they want to have relationships with the clinics that serve those members. So on a case-by-case, an individual qualified health plan by qualified health plan, we've been having discussions. What I would like to do—what I am asking you and your clinic providers to do, is to take that list that will be distributed and talk to the health plans that are in your area. Because what I am really hoping to encourage here today is a relationship between the clinic provider and the health plan.

And we are not in the position of creating a list of all the hospitals that are contracted. We don't create a list of all the FQHCs that are contracted. We're not putting those kinds of lists together. What I would like to do is help facilitate your various Native American clinics to talk to the health plans that are in their market areas.

VIRGINIA: So if I'm understanding you correctly, Covered California will not be issuing a list of ITU providers that are networked with qualified health plans?

LEAH: No, there is not a plan to do that. What we are looking to do is the provider directory online to be sufficient enough to be able to look up the relationships.

VIRGINIA: And at this point, the provider directory is insufficient; you do have to do it by physician. I know at the California Rural Indian Health Board, we have a list of all of our member physicians, and so we've been compiling that list. I believe

Stacy Kennedy is bringing the most up-to-date list we have by physician, but we have concerns on how those contracts work, what happens when the physician leaves the clinic, which is a common occurrence in Indian Health Programs. And then for those who are not member clinics and we don't know all those physicians, which is still a number of clinics, we won't be able to provide anybody that list. And therefore, down to the consumer level, the Indian person who's trying to buy a plan and wants to be able to continue to receive culturally competent and relevant care at their Indian Health Program is at the risk of selecting a plan that may or may not be one that they can take to their Indian Health Program.

LEAH: I want to reiterate what Peter talked about this morning, which is the Indian community is fully entitled to continue to receive services at the clinic, their traditional source of care at that clinic, which is an important point in terms of the relationship that we're teaching the qualified health plans about. Again, if enrollees are in one of their plans and receive services at a clinic that is not in their network, they need to understand about what their responsibility is for payment and what their responsibility is for additional referral relationships. So it's important that we learn from you and teach together our qualified health plans.

VICKI: Thank you. It's kind of hard, because I was sitting back there and I couldn't see, and I was trying to take notes. That's why I asked if we had that. I have that bad memory. So you were giving some explanation of stuff. So I wanted to be able to have that, whether it's on the web or something for us to read. But that's not why I'm up here. The question I have is—we had a tribal meeting, and I went to our tribal people and I'm telling them about Covered California, but the one question they asked me is, "Well, when should I start?" And I'm telling them, "I don't know," because the main things that we are looking at is the networks that are going to provide with our clinic. And if I can't tell them that, they're not sure what plan they want to take. And then you said that the physician names are going to change, and you guys are going to try and put the clinics on there. That's great. And I heard you say it's going to take a while.

So in my mind, I feel like I should tell my members, "Don't apply yet, because it's going to take a while for you to find a clinic on there," because not all of our doctors are always the same doctors we see. We're a clinic. We have rotating doctors. Sometimes we have temporary doctors. How is that going to affect those health plans? If we have somebody we get from a temp agency, is it our contract that they're going to abide by the payment to us, or they're going to say, "This doctor isn't in our list. We're not going to pay you for that visit." That's a big concern.

And I just heard what you said about, "Well, you guys have your clinics and your IHS money." I don't know if you guys in Covered California are aware. We are never funded properly. We are never given enough money to serve all of our people, [applause] so that isn't really an option. I'll let you talk. I'll just throw this

all out so you can tell me everything I need to know. That out-of-network is a big problem, because when we refer people out, if that health plan isn't going to be included as their network, and we send somebody and refer them out and we don't get monies, that has to come out of contract health support, which is even less funded for us in our clinics. So these are matters to us and why we wanted that. That strong letter really didn't feel like it was enough, but we wanted that recommendation because if we don't have the funds, our clinics close. And then our Indian people aren't even a part of the affordable healthcare. And as you know, being even the tribal consultation you did, there's a special thing in there for us Indian people, that we are kind of now getting concerned. We don't want our clinics closed because we're not getting the proper funding because those health providers are not contracting with us. Thank you. [applause]

LEAH: Thank you for sharing your comments and your concerns. I want to make sure that—I think one thing I was referencing maybe was misunderstood. I was not saying that an enrollee of a health plan would go to the clinic, and that clinic would not be able to bill the plan. So the issue around internal payment, in terms of Indian Health Services payment for that member—we understand that if a member is enrolled in, say, Blue Shield, and they seek services and receive services at one of our clinics, that your clinic is entitled to bill the health plan and receive compensation for that. So those are messages that we're sharing with our qualified health plans. We're talking to them about how they need to understand that and how they need to understand that it's in their interest to have contracts with you in order to create relationships that are more smooth, so that everyone understands referral expectations, understands compensation expectations. And so I was not suggesting that the payment for that patient would come from your already challenged funding resources.

DENISE: I'm Denise Paget(?) from [..?..]. Our concern is also with locums. We live in a very rural area, so we don't have permanent providers. We just go through locums like crazy. So can the contract be made just for the clinic specifically and not the individual provider?

LEAH: Thank you for the question. Yes. This is actually one of the things that is part of our discussion with the whole world of clinics, whether they're your clinics or federally qualified health centers or 1204(a) clinics. There's a lot of recognition and awareness that the member goes to the clinic not to the traditional physician provider, per se. And I think what you're raising is, well, if that provider, that physician or whomever moves on, in some circumstances the patient then continues to be assigned to that provider and they move on to whatever is the next source of services that that provider is working for. In the clinic world, the patient stays with the clinic. And we at Covered California have been having a lot of dialogue to ensure that our systems of provider directory allow that to be shown.

I'll reiterate again. The directory is not what I would like it to be, absolutely not what I would like it to be. But we are very clear that the member stays with the

clinic. Particularly—thank you for pointing out in your circumstances that there are physicians who come from our places. They're locums. They're only there for a short period of time. They're working for some particular window of time. And again, that point in the addendum that talks about the license, that they could be licensed in North Dakota or Florida or whatever and they're here for a period of time. Some really important points. Some of this is an education to our qualified health plans, and it makes me even more looking to Katie over here. I think that a meeting that specifically tied having our qualified health plans and some of your—whomever you would like to send to a meeting to help educate those QHPs about those points would be valuable. I appreciate the point.

JIM: Jim Crouch, California Rural Indian Health Board. I appreciate that you're doing some great work, and you're moving in the right direction. And I think facilitating those conversations is a good next step. I guess one clarifying thing, to follow up on Denise's question: There's nothing in your master contract that prevents your qualified health plans from contracting with clinics, not providers, not doctors.

LEAH: There's nothing in our model contract between us and our qualified health plans that would prevent that.

JIM: Great. I would like to give you a framework for those conversations that you're trying to engineer. I think we could, aside of your structure, also try to do that ourselves. Tribal Health Programs have always seen themselves as the medical home for the community they serve. They want to case manage those individual clients. If someone is enrolled in a health plan and the health plan's not got a contractural relationship with the clinic, then that relationship is broken because you're requiring—the plan would say, "Our primary care provider is Dr. X." The client, the Indian, and the clinic would say, "No, it's the Tribal Health Program." So, in essence, they would be forced to be managed under the plan by someone that they didn't see in that role. And if they came to the Indian Clinic, they wouldn't have a way to communicate the health problems that were discovered at the clinic, to get access to the rest of that network, the value of the plan. And if they go to the health plan and their primary care doctor doesn't share information with the Tribal Health Clinic, then the client's health status is being changed, but nobody at the Tribal Health Program is made aware of it. That rupture in relationship is terribly important.

One of the reasons that it should be of value to the plans that they establish and maintain that relationship is that part of what we have that the average physician network doesn't have is a huge commitment and investment in public health kinds of services. We have special clinics for diabetics. We have special programs for people with substance abuse problems. We have a lot of community-based outreach home visit kinds of services. If the relationship between the plan and the clinic isn't coordinated and under contract, the value of that IHS and tribal investment in preventive and community health is thrown away.

LEAH: Thank you for those comments. I want to suggest that actually you all have a lot to teach some of the other parts of the healthcare system. I personally am a fan of the clinic world, whether it's a rural or inner-city, urban setting. I recognize that the comprehensive services, the culturally competent services, the onsite pharmacy sometimes, onsite lab, onsite radiology services on some occasions, onsite case management programs, onsite diabetic education programs are all important services that you offer and some of your federally qualified health center partners offer. And these are some of the things that we want to encourage the health plans to be more active and involved with understanding the membership and getting them into those medical home types of settings.

There are requirements in our model contract about moving forward the concept of medical homes and moving forward the concept of coordinated care. There are some health plans that have been doing this for quite a while, and there are some that are learning about it. And I think that they have a lot to learn from you, in terms of especially your population and how to work with them. Again, I think this is one of the education things that we are working to bring our qualified health plans into some understanding. There are some who very much understand this, who totally understand this. And there are some for whom this is brand new. So you teaching them is probably the best way for us to have them understand this information.

JILL: Hi, Leah. Jill Martin with Sekooi(?). I had a question about how to operationalize the no-cost-sharing protections at our clinic. How are the Indian clinics going to be held harmless or receive full reimbursement from the QHPs when they don't collect the cost sharing from the Indian patient? Who absorbs the cost? Who pays? How is that going to work?

LEAH: I'm looking over to my policy colleagues for a minute here. We've had a couple of discussions about this. I've had a couple of discussions with the QHPs about understanding that that revenue is coming from the feds, not from the member, and recognizing that they're going to need to operationalize that at the local level, with your clinic. I don't have a specific answer for you, but that's another one of the discussion points to have with our QHPs, if we facilitate a meeting like this.

JILL: I also think it's an integral answer for our clinics that are considering contracts with QHPs. How are they going to be held harmless? So on the patient side then—I just want to get this out, too—how are Indian patients going to be identified in the system and acknowledged by providers as not having cost sharing if they present in a non-Indian-clinic setting?

LEAH: Well, usually how that's done is an ID card, in traditional methods for managed care. It's usually done through an ID card that would identify the patient's cost share on the card, the patient's group on the card. That would be how I'm anticipating that we're doing it, but I will have to look into that and double check for you. But usually that's on an ID card.

JILL: Thank you.

DANNY: Danny Jordan from the Hoopa Tribe. I want to follow up on what Jim just said. We have this thing. We don't need code talk in Indian country, and we definitely don't—and the comments that are made—we have fought more battles than anybody understands to get healthcare systems in California that work, and especially in these rural areas. Jim's point is exactly right on, and that is one of those trapdoors. If the Affordable Care Act becomes a mechanism for outside providers to come in and intervene in our healthcare system and start dividing out, "The Indians are going to apply for this," to carve up our healthcare system, I know at Hoopa we will say, "Keep it out." We don't need a plan that's going to contribute to what has historically been the chopping up of Indian healthcare in California. We need the United States to simply honor their relationship.

Everything we've heard today has been that the Affordable Care Act is an improvement, is a partnership. But if these plans end up being competitors for our healthcare systems, it isn't going to work. And it needs to be understood that that creates this huge trapdoor right at the boundaries of these Indian healthcare programs. If anybody is thinking that anybody can come into Indian country just because they have gotten a status of being one of these healthcare providers in these plans, and they're going to just simply invade Indian country, it's not going to happen. We're dealing with ambulance programs and those kinds of things, real life-saving situations, and we don't get a lot of help. We need partners. We don't need competitors. Jim's comment is a threshold issue in Indian country, that that isn't an understanding from day one, go back and rethink the plan. [applause]

LEAH: Thank you. I think you've actually raised a point that is important for our qualified health plans to understand, which is there are—as I'm learning, and you can correct me—certain… The clinic providers serve the community that they're built to serve. And so non-eligible persons cannot seek services at those providers unless under a set relationship. So the clinic is set to serve the members of the tribe—no? One of the concerns I have about provider directory is ensuring that we don't somehow indicate that your services are available to a broader array and then overwhelm some of your offices or your services. So that's one of the challenges with the provider directory that would display a clinic, and possibly others who see that there may see that think that that's a provider that they can go to, when they may not be eligible for services in one of your clinics. That's a concern I have.

DANNY: I just want to clarify that non-Indians are entitled to services at any Indian clinic on a fee-for-service basis. Again, if the plan comes up, carving out our populations in Indian country to these categories of services, it's gutting our healthcare systems.

LEAH: Thank you.

MICHELLE: My name is Michelle Hayward. I'm from Redding Rancheria in Northern California, and I am the chair of CRIHB. It is very frustrating. I think it's frustrating for all of us, because we are worried about our patients leaving us and going somewhere else. It is frustrating and it's scary for every one of our tribes. Then we have something new, and I'm supposed to like all the healthcare and all these changes. And as long as it benefits us, I would like it. I don't see a whole lot of benefit to me, because I feel like pretty soon IHS is going to say, "Oh, they all have healthcare." To me, this is like underlining something that's going to happen later on in the future that concerns me. This is just me personally. You guys don't have to have tribal consultation with us because you're not part of the feds. We get told we have to deal with the states. It's been very hard to deal with California for many years, for people older than me who have been fighting this same fight for a long time.

So here we are, teaching you guys about us again. It's just like this cycle that's always happened, and we'll continually do it. But I do hope that you just take that letter that we all wrote, everybody did yesterday, in consideration. I think we are all worried about losing all of our people and our health clinic. We're already funded at 56%. We're not even fully funded. We've done a great job. All of our health clinics are great. We do it the best, I think, than we do in other QHPs, or whatever, qualified health plans. So I think Tribal Health Programs have been doing it for so long for their people, I think we do great. I definitely want to see the non-federally recognized Natives—that is in your letter—be in there. I'm looking up you guys' application. It's only federal. I realize that it's the law. But they are Native Americans. It's not their fault they're not recognized. That's all I have to say.

LEAH: Thank you for those comments.

CHARLENE: I'm Charlene Storer with Tolowa Nation (non-federally recognized) a descendent of many people who worked to bring healthcare to California Indians when the Indian Health Service left the state. I think the healthcare that's provided to us here in California is excellent. I hate to see things that come up and divide us again. We've worked so long and hard to get the descendants into the system for the healthcare that we deserve. I hate to see—when the gentleman spoke about the division, because this is what I've seen over the years through governments trying to work with Indians. It's like we have to re-educate. Every time we turn around, we have re-educate. It becomes very discouraging to have changes in the system that make you have to re-educate every time you turn around. Just know that Indians are here. Indians are not going away. We want to take care of ourselves. Sometimes we're in a situation where we can work for each other and work with each other, and sometimes there are situations where we cannot. But know that we're not going away.

I heard someone say earlier, and I don't remember if it was you or if it was Peter that said it, about advising and working with federal government, that you couldn't make policy. And I understand that part. But I do understand that you do have a voice with the federal government through Covered California, through the California Exchange, that you can make known what's happening in California. So I would expect Covered California to step up to the plate and say, "Hey, this is the situation in California." And I have to say that in the rest of the states in the United States, there are other non-federally recognized tribes; it's not just California. So we expect—at least I expect—Covered California, from what I've been hearing, to step up to the plate and say, "This is the situation. This is how we can resolve it." I don't expect you to tell them that they have to do it this way, but give them some options and let them know that we are out here and we expect our federal government to stand up.

FSPKR: I got carried away. I had a question when I came up here. [laughter] That's on your model. And I'm wondering why you guys are waiting until 2015, instead of getting it done by 2014.

LEAH: The answer to that question is those contracts for 2014 have already been fully executed. That was done back in July or August. So those contracts are in place now, and we're working with the plans on those contract terms currently. The next cycle of changes to that contract would be for the 2015 contract, which doesn't mean we're not—as I shared, we put the addendum out to the plans. I've had phone calls with the plans to make sure that they're aware of the addendum, to talk about some of the things that are important, that they need to understand in terms of the terms of the addendum. I think having a chance to have direct conversations with your organizations and those plans is another way to make sure that that addendum is recognized or understood. But the next time to do something in the model contract is for the 2015 contract.

I just want to comment about the idea of the letter that you shared with us. I think I'm going to reiterate that we, at Covered California, take all of the input that we get from stakeholders and review it and consider it. And I know that your letter will come to the team and be reviewed closely. We want to understand what are the challenges and what are the issues. The other thing I do know is that the team at Covered California has been working very diligently to ensure that we meet your requests for consultation and Tribal Work Group. It's a very active part of our weekly discussions amongst the team members at Covered California about this area. So I hope I can reiterate that this is an area that we are very conscious of and very aware of learning and working with you all. David?

DAVID: Could I make a comment? I'm David Maxwell-Jolly, the chief deputy at Covered California. I wanted to respond to the suggestion that while it's true we don't have the ability to advocate a particular change in law, Peter's response to that point in the letter was very much in line with your suggestion. We do have the ability to talk with our overseers in the federal government and to communicate with them

the conditions in California, and give them the facts on the ground, tell them the consequences of the exclusion of non-recognized tribes, in terms of the people in California. I think we very much appreciate your suggestion that we make sure that the folks we're working with in Washington understand those consequences. I think we definitely can do that.

CONNIE: Yes, I just wanted to make a couple of comments. My name is Connie Wrightman(?). I'm [..?..] from Big Valley area in Lake County. I think one of the things—I appreciate the comments of the woman before me, regarding the makeup of the Indian healthcare system in California. I think a lot of people ignore the capacity of the tribes to take a serious challenge in our community and work together as tribal people to develop a system that is more responsive to our population. What it was, was the infant morbidity and mortality rate of our Indian children throughout California, including two of my brothers, who were born without appropriate prenatal care, and my aunts and cousins and sisters—everyone looking for how we could stop our babies from dying. And so we went to the Bureau of Maternal and Child Health in Berkeley. Nine projects were started out of that, with 200-something thousand dollars. And the tribal leaders of California took that 200-something thousand dollars and developed it over a period of so many years to 33 multi-million-dollar healthcare systems that Indian Health Service could not provide. The tribes did.

So what we know about what the tribes have also done, not only about healthcare, was to improve the healthcare education of people who were going to be working with our people. In addition to that, we were able to employ healthcare professionals who otherwise would not be employed in rural areas of California. Added to that is the value of the pharmaceuticals, the medical supplies, the equipment and the benefits that are paid out in our local communities that are driving the economy of California's rural areas. From the perspective that I understand this is what we are being told is that irregardless of if we meet federal, state or county standards or exceed them, we are still not allowed to have a voice in this whole process.

We have a tremendous resource in this room of individuals who have worked diligently over the past decade to create a healthcare system that stands above many others. So it is very disturbing to hear that policies and procedures continue to be put into place that create barriers for our tribal governments to participate in healthcare systems evolution, development, design, content, etc., etc. I say this with compassion and due respect to all the leaders in the room that we can't afford to allow these kinds of activities to disrupt the progress that our tribal leaders have made in the past decade. We want to respect the leadership of the California Rural Indian Health Board, who has brought these issues to our attention time after time on behalf of all our people. We are not even remotely close to the end of the trail where we can see our children being raised in safe and healthy environments. It is our hope to achieve that change in our lifetime so that

our people will not continue to suffer the trauma that our ancestors and forefathers have had to bear.

From what I can hear as I listen to these people talk, they are advising you appropriately and adequately beyond the capabilities of other entities to provide the service needed by our people. Our tribal communities cannot depend on Kaiser or Sutter or any other healthcare system, because they're not designed to address our needs. We have multi-million-dollar healthcare systems, governed by California-recognized tribal people and our brothers from our tribes in the urban areas. We seek to be heard. It is our responsibility to provide the healing and care for our tribal people, and our voice needs to be heard. Thank you for this opportunity. [applause]

LEAH: Thank you. Well, I appreciate those words. I appreciate your honesty in sharing your feelings and your concerns with those of us from Covered California. We hear you sincerely. We understand that you have had a great deal of time and history in this arena, and we are attempting to work with you and understand what we can do to support you and be part of your efforts to improve care for your members, and do what we can to facilitate relationships with our partners. We look forward to working with you down the line tomorrow as we continue to develop those opportunities to work with you and learn from you. I appreciate your honesty and your sharing your observations with us. Thank you. That looks like all the questions. Thank you. [applause]

MARK: Thank you again, Leah. I know in the work that we're doing together, there's issues in implementing a new healthcare system. We're working to iron them out together. We're here to do that very thing. I know sometimes it may be a little tense, and it's not always easy, but we need to continue to stick together and work collaboratively and cooperatively towards the goal that the tribal representatives and the urban Indian representatives have, and that is to have the ability to serve their Indian patients going forward in the new healthcare delivery system.

With that being said, I'm the bearer of good news—there's food in the back. We'll go ahead and move into lunch a little early. There's a lot of great sandwiches back there. We had our prayer already this morning, so we'll just move right into lunchtime. Network, visit, debate if you'd like—whatever you'd like to do. This is your time. We'll see you for the next presentation after lunch.

[END OF RECORDING]